City of San Jose Custom ASO PPO 100 90/70

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueshieldca.com/policies or by calling **1-800- 872-3941**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** per individual / **$200** per family. Does not apply to emergency room facility services not resulting in admission, participating physician and specialist office visits, breast pump, routine outpatient mental health and substance use disorder services, family planning counseling and consulting, tubal ligation, diabetes self-management training, preventive health services and outpatient prescription drug benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers and non-participating providers: **$2,100** per individual / **$4,200** per family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, some cost sharing, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Questions: Call **1-800- 872-3941** or visit us at **www.blueshieldca.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.blueshieldca.com **or call 1-800- 872-3941** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 13. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment / visit	30% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject to the calendar-year medical deductible at participating providers.
	Specialist visit	$25 copayment / visit	30% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject to the calendar-year medical deductible at participating providers.
	Other practitioner office visit	Chiropractic spinal manipulation: 10% coinsurance Acupuncture: 10% coinsurance	Chiropractic spinal manipulation: 30% coinsurance Acupuncture: 30% coinsurance	Coverage for chiropractic services is limited to 20 visits per calendar year. Coverage for acupuncture services is limited to 20 visits per calendar year. Additional member cost-share applies for covered X-ray services received in conjunction with the office visit.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by participating providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details. Not subject to the calendar-year medical deductible at participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free Standing Location: 10% coinsurance X-Ray & Imaging at Free Standing Radiology Center: 10% coinsurance Other Diagnostic Examination at Free Standing Location: 10% coinsurance X-Ray, Lab & Other Examination at Outpatient Hospital: 10% coinsurance	Lab & Path at Free Standing Location: 30% coinsurance X-Ray & Imaging at Free Standing Radiology Center: 30% coinsurance Other Diagnostic Examination at Free Standing Location: 30% coinsurance X-Ray, Lab & Other Examination at Outpatient Hospital: 30% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. X-Ray, Lab & Other Examination at Outpatient Hospital: The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free Standing Radiology Center: 10% coinsurance Radiological & Nuclear Imaging at Outpatient Hospital: 10% coinsurance	Radiological & Nuclear Imaging at Free Standing Radiology Center: 30% coinsurance Radiological & Nuclear Imaging at Outpatient Hospital: 30% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. Radiological & Nuclear Imaging at Outpatient Hospital: The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350. Pre-authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com .	Generic drugs	Retail: $10 copayment / prescription Mail Order: $20 copayment / prescription	Retail: 25% of billed amount + $10 copayment / prescription Mail Order: Not Covered	Retail: Covers up to a 30-day supply; Mail Order: Covers up to a 90-day supply. Select formulary and non-formulary drugs require pre-authorization.
	Brand formulary drugs	Retail: $25 copayment / prescription Mail Order: $50 copayment / prescription	Retail: 25% of billed amount + $25 copayment / prescription Mail Order: Not Covered	
	Brand non-formulary drugs	Retail: $40 copayment / prescription Mail Order: $80 copayment / prescription	Retail: 25% of billed amount + $40 copayment / prescription Mail Order: Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	10% coinsurance of the Blue Shield contracted rate up to $100 copayment maximum / prescription	Not Covered	Covers up to a 30-day supply. Blue Shield's Short Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply. In such circumstances the specialty drug copayment/coinsurance will be pro-rated. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment / visit + 10% coinsurance at a free-standing ambulatory surgery center $100 copayment / visit + 10% coinsurance at a hospital-affiliated ambulatory surgery center	30% coinsurance	The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copayment / visit	$100 copayment / visit	Copayment waived if admitted; standard inpatient hospital facility benefits apply. Not subject to the calendar-year medical deductible. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------None----------
	Urgent care	$25 copayment / visit at freestanding urgent care center	30% coinsurance at freestanding urgent care center	Not subject to the calendar-year medical deductible at participating providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment / admission + 10% coinsurance	30% coinsurance	The maximum allowed amount for non-participating providers is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600. Pre-authorization is required for all services. Failure to obtain pre-authorization for special transplant services may result in non-payment of benefits.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance use disorder needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Services: $25 copayment / visit Mental Health Non-Routine Outpatient Services: 10% coinsurance	Mental Health Routine Outpatient Services: 30% coinsurance Mental Health Non-Routine Outpatient Services: 30% coinsurance	Mental Health Routine Outpatient Services: Services include professional/physician office visits. Not subject to the calendar-year medical deductible at participating providers. Mental Health Non-Routine Outpatient Services: Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, psychological testing, and transcranial magnetic stimulation. Failure to obtain prior authorization for any Non-Routine Outpatient Mental Health Services will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Services: $100 copayment / admission + 10% coinsurance Mental Health Residential Services: $100 copayment / admission + 10% coinsurance Mental Health Inpatient Physician Services: No Charge	Mental Health Inpatient Hospital Services: 30% coinsurance Mental Health Residential Services: 30% coinsurance Mental Health Inpatient Physician Services: 30% coinsurance	The maximum allowed amount for non-participating providers is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600. Failure to obtain prior authorization for a Mental Health Inpatient Admission will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Substance Use Disorder Routine Outpatient Services: $25 copayment / visit Substance Use Disorder Non-Routine Outpatient Services: 10% coinsurance	Substance Use Disorder Routine Outpatient Services: 30% coinsurance Substance Use Disorder Non-Routine Outpatient Services: 30% coinsurance	Substance Use Disorder Routine Outpatient Services: Services include professional/physician office visits. Not subject to the calendar-year medical deductible at participating providers. Substance Use Disorder Non-Routine Outpatient Services: Services include partial hospitalization programs, intensive outpatient programs, and office-based opioid treatment. Failure to obtain prior authorization for any Non-Routine Outpatient Substance Use Disorder Services will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder inpatient services	Substance Use Disorder Inpatient Hospital Services: $100 copayment / admission + 10% coinsurance Substance Use Disorder Residential Services: $100 copayment / admission + 10% coinsurance Substance Use Disorder Inpatient Physician Services: No Charge	Substance Use Disorder Inpatient Hospital Services: 30% coinsurance Substance Use Disorder Residential Services: 30% coinsurance Substance Use Disorder Inpatient Physician Services: 30% coinsurance	The maximum allowed amount for non-participating providers is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600. Failure to obtain prior authorization for a Substance Use Disorder Inpatient Admission will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.
If you are pregnant	Prenatal and postnatal care	Prenatal: 10% coinsurance Postnatal: 10% coinsurance	30% coinsurance	Prenatal: $25 copayment for initial visit only.
	Delivery and all inpatient services	$100 copayment / admission + 10% coinsurance	30% coinsurance	The maximum allowed amount for non-participating providers is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider member cost share. Pre-authorization is required.
	Rehabilitation services	Office visit: 10% coinsurance Outpatient hospital: 10% coinsurance	Office visit: 30% coinsurance Outpatient hospital: 30% coinsurance	Coverage for physical, occupational and respiratory therapy services. Outpatient hospital: The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350.
	Habilitation services	Office visit: 10% coinsurance Outpatient hospital: 10% coinsurance	Office visit: 30% coinsurance Outpatient hospital: 30% coinsurance	
	Skilled nursing care	10% coinsurance at freestanding skilled nursing facility. 10% coinsurance in a skilled nursing unit of a hospital	10% coinsurance at freestanding skilled nursing facility 30% coinsurance in a skilled nursing unit of a hospital	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility. Pre-authorization is required. Hospital Skilled Nursing Unit: The maximum allowed amount for non-participating providers is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	10% coinsurance	30% coinsurance	No charge for breast pump from participating provider. Pre-authorization is required.
	Hospice service	No Charge	Not Covered	All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.) Failure to obtain pre-authorization may result in non-payment of benefits.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------None----------
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (unless enrolled in a participating hospice program)
- Routine eye care (Adult/Child)
- Routine foot care (unless for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture (coverage limited to 20 visits per calendar year)	• Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits)	• Chiropractic care (coverage limited to 20 visits per calendar year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800- 872-3941**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323** X **61565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-800- 872-3941** or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care Help at **1-888-466-2219** or visit http://www.healthhelp.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 로 전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。

Persian (فارسی): برای دریافت کمک به زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (پنجابی): پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے کال کرو۔

Khmer (ភាសាខ្មែរ): សម្រាប់ជំនួយជាភាសាខ្មែរ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic (العربية): لحصول على المساعدة في اللغة العربية ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab Hnoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทย โปรดโทร 1-866-346-7198.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,460
- **Patient pays** $1,080

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Copays	$120
Coinsurance	$710
Limits or exclusions	$150
Total	**$1,080**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$650
Coinsurance	$130
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800- 872-3941** or visit us at www.blueshieldca.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call **1-866-444-3272** to request a copy.